April 2006

Massachusetts Board of Registration in Pharmacy

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1. Policy 2005-01

Continuation of Drug Therapy Upon Discontinuance of a Practitioner's Practice – A Joint Policy of the Department of Public Health, Drug Control Program and Board of Registration in Pharmacy

When a pharmacist becomes aware that a practitioner, or other person authorized to prescribe in accordance with M.G.L. c. 94C, has ceased to practice for any reason and that the practitioner-patient relationship has ended, existing drug therapy may still need to be continued. Therefore, a pharmacist may, pursuant to a prescription previously issued by that practitioner or other authorized prescriber and in the exercise of good professional judgment, dispense remaining refills of a prescription up to a maximum 90-day supply, to enable the patient to establish a relationship with another practitioner. Refills authorized pursuant to this policy may not be dispensed in quantities greater than a 30-day supply in a single filling, except where patient insurance coverage requires dispensing of a 60- or 90-day supply.

2. Letter from the President

By George A. Cayer, RPh

It is truly an honor to serve as president of the Massachusetts Board of Registration in Pharmacy for 2006. The practice of pharmacy is always changing and 2006 will be no different. Some of the opportunities and challenges facing the Board under my presidency this year are:

a. Ongoing education of pharmacists regarding the implementation of continuous quality improvement (CQI) program requirements of 247 Code of Massachusetts Regulation 15.00. Quality must be the focal point of all licensed pharmacies in Massachusetts;
b. Ongoing education of the important role pharmacy technicians have in supporting pharmacists in every patient setting;
c. supporting Collaborative Drug Therapy Management concepts; and
d. ongoing education to consumers and pharmacists regarding new laws for dispensing emergency contraception (EC).

I ask all Massachusetts pharmacists to closely examine their evolving responsibilities in the health care system. The role of pharmacists continues to expand and we should all embrace the changes and be aware of these new responsibilities. In the coming year, I ask all of you to identify one major issue of importance to your practice and become more personally involved with it. Together, we can make the practice of pharmacy all that it is meant to be and improve our professional image in the communities we serve.

3. Clarification of Technician Registration Requirements

Since registration issues involving certain individuals employed as pharmacy technicians in Massachusetts pharmacies continue, the Board believes it is necessary to reiterate the message that appeared in the April 2005 *Newsletter*.

All individuals employed as pharmacy technicians in the Commonwealth **must** (after completing required training and examination) file an application for registration as a pharmacy technician with the Board. Every two years **after** the initial registration period, all pharmacy technicians are **required** to file a renewal application with the Board. Please be reminded that Pharmacy Technician Certification Board (PTCB) certification is **not** the equivalent of the state-mandated requirement of current registration with the Board for employment as a pharmacy technician in the Commonwealth. The Board is aware of individuals who have achieved PTCB certification and began employment as technicians without applying for registration by the Board, as required by M.G.L. c. 112, §24C-24E. Other individuals who have achieved PTCB

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certification after registering as pharmacy technicians with the Board have then failed to renew their technician registration with the Board after the initial registration period. Since current registration by the Board is statutorily mandated for employment as a pharmacy technician in the Commonwealth, any individual employed as a pharmacy technician who is not in compliance with state laws and Board regulations (247 CMR 8.02-8.07), as well as any pharmacist and pharmacy employing such person, risks adverse action by the Board and law enforcement authorities for unlicensed practice.

4. Joint Guideline for Pharmacist Dispensing of Emergency Contraception

The Department of Public Health (Department), specifically the Board of Registration in Pharmacy (Pharmacy Board), the Board of Registration in Medicine and the Drug Control Program under authority of M.G.L. c. 94C, have adopted Guidelines (Pharmacy **Board Policy No**. **2006-1**) that describe the requirements for pharmacists to dispense Emergency Contraception (EC) pursuant to M.G.L. c. 94C, § 19A in accordance with a written standardized procedure or protocol (i.e., Standing Order) developed by an actively practicing physician registered with the Commissioner to distribute or dispense a controlled substance in the course of professional practice pursuant to M.G.L. c. 94C, §7. Pursuant to the statute, the Standing Order must be maintained on file at the participating pharmacy and a copy filed with the Pharmacy Board. In addition to requirements for dispensing, these Guidelines set forth requirements for training and reporting.

Physician Orders Are Required to Dispense EC

Prior to the enactment of Chapter 91 of the Acts of 2005, a prescription from an authorized prescriber in compliance with Department regulations was required to dispense EC (e.g., Plan B).

In accordance with M.G.L. c. 94C, § 19A, a pharmacist may now alternatively dispense EC pursuant to a Standing Order developed by an actively practicing registered physician (see the Guidelines below). Standing Orders must include written, standardized procedures and protocols; the printed name and signature of the physician; and the entity(ies) authorized by the Physician.

A physician may issue a Standing Order for a pharmacist, pharmacy or group of pharmacies under common ownership or control of one entity.

Guidelines for Dispensing EC Pursuant to Standing Order

Prerequisites

A pharmacist may dispense EC pursuant to a Standing Order of an actively practicing physician who is registered with the Commissioner provided that:

a. the pharmacist is currently licensed by the Pharmacy Board;
b. the pharmacist has completed training accredited by the Accreditation Council [for] Pharmacy Education (ACPE) or offered by an "Approved College or School of Pharmacy" (247 CMR 2.00), which training shall include instruction on:
    1. referring patient for additional service and follow-up;
    2. quality assurance; and
    3. proper documentation.
c. the Standing Order is maintained on file (readily retrievable) at the pharmacy; and
d. a copy of the Standing Order has been filed with the Pharmacy Board.

Training

Proof of training must be on file (readily retrievable) at the pharmacy.

Filing

A copy of the Standing Order must be maintained on file (readily retrievable) at each participating pharmacy site.

One copy of the Standing Order must be filed with the Board. Where a Standing Order provided to the participating pharmacy includes a certification that the Order has been filed with the Board, it is not necessary to make duplicate filings with the Board.

Offer to Provide Medication Counseling

As currently required by M.G.L. c. 94C and Pharmacy Board regulations 247 CMR.

Required Reporting

In accordance with M.G.L. c. 94C, § 19A(d), annual reporting of dispensings is required. Where possible, reports shall aggregate the total number of units of use dispensed pursuant to a Standing Order (not including units of use dispensed pursuant to a prescription). Reports are not public records and shall not include any patient names or identifiers.

Annual reports must be electronically submitted to the Department not later than August 1st for the period from July 1 through June 30 of the prior year.

An authorized representative for a group of pharmacies under common ownership or control of one entity may report on behalf of all pharmacies, provided subtotals are submitted for each location by permit number (and zip code).

A reporting format will be available on the Department's website.

Reports shall be submitted electronically to the Department. Instructions will be provided on the Department's website.

5. Massachusetts Professional Recovery Program

Program for Chemically Dependent Pharmacists and Allied Health Professionals

"Licensed professionals reaching out to help other licensed professionals cope with alcohol and drug problems."

For **confidential** information please contact the Massachusetts Professional Recovery Program (MPRS) Coordinator Tim McCarthy at 617/973-0910 or visit the MPRS Web site at www.mass.gov/dpl/services/mprs.htm.

6. Frequently Asked Questions About Implementation of Chapter 91 of the Acts of 2005 'Timely Access to Emergency Contraception' (March 2006)

Pharmacy Training, Filing, and Practice

1. **Question:** Is a pharmacist required to provide EC to a pharmacy customer who does not have a prescription?

   Answer: No.

Dispensing under a standing order is voluntary. In accordance with M.G.L. c. 94C, §19A, a trained pharmacist may now alternatively dispense EC pursuant to a standing order developed by an actively practicing registered physician. See Board Policy No. 2006-1.

Prior to the enactment of Chapter 91 of the Acts of 2005, a prescription from an authorized prescriber in compliance with Department regulations was required to dispense EC.

2. **Question:** Can a pharmacist dispense Plan B pursuant to a standing order if he or she completed training required by M.G.L. c. 94C §19(A)(c) prior to implementation of the law on December 14, 2005? (Or, does the pharmacist need further training?)

   Answer: Generally, yes if the pharmacist has completed the substantive training prerequisites.

The new law specifies training content areas that must be mastered prior to a pharmacist dispensing EC per a standing order. Board Policy No. 2006-1 requires that proof of training must be on file (readily retrievable) at the pharmacy.

Those pharmacists who received training prior to December 14, 2005, are advised to consult with ACPE or the approved college or school of pharmacy where the pharmacist received training to make sure that such institution has provided the pharmacist with requisite proof of training on the following topics:

- Referring patient for additional service and follow-up;
- Quality assurance; and
- Proper documentation.

If the certificate of completion issued by ACPE or the approved college or school of pharmacy is dated before December 14, 2005, ACPE or the approved college or school of pharmacy that issued the certificate of completion may provide the pharmacist with additional documentation on its letterhead that clarifies that the training offered on a specific date covering the topics required by Board Policy No. 2006-1.

If the pharmacist does not have requisite proof of training from ACPE or the approved college or school of pharmacy where he or she received training or the training curriculum did not cover requisite topics, the pharmacist is advised to seek further training to document that he or she possesses requisite qualifications.

3. **Question:** If a pharmacist works in multiple locations, as a "floater," does the pharmacist need proof of training to be readily retrievable in each location (or just in his or her home location)?

   Answer: Yes. A pharmacist must have proof of training readily retrievable at each location in which the pharmacist dispenses EC pursuant to a standing order.

The best practice is for the pharmacist to file a hard copy of the training certificate with each work site so that the pharmacy may make such proof available to Massachusetts Department of Public Health (MDPH) inspectors upon request. Alternatively, if the pharmacy where the pharmacist works can readily retrieve or download a copy of training certificate(s) of completion via the Internet (using a unique identifier assigned by an approved college of pharmacy), or any other electronic means of transmitting proof of training, such as by fax or e-mail attachment, maintenance of a hard copy at each work site is not necessary.

4. **Question:** How will a pharmacist know that a particular standing order signed by a particular physician has been filed with the Board of Registration in Pharmacy and is ready for use?

   Answer: See best practice suggestion(s) for physicians (Question No. 9 below).

5. **Question:** If a pharmacy has a standing order on file at the pharmacy and at the Board of Registration in Pharmacy that authorizes the dispensing of Plan B per the standing order by any qualified pharmacist practicing at that location, must all pharmacists who practice at that pharmacy location dispense Plan B under the standing order?

   Answer: No.

The new state law on timely access to EC does not require all pharmacists employed at a particular location to dispense under a standing order. Conditions of employment and scheduling of shifts of pharmacists who opt to participate are matters left to the management prerogative of the employer.

6. **Question:** Is it necessary for minors (persons under age 18) to obtain parental consent to obtain EC medication from a pharmacist or pharmacy that is authorized to dispense under a standing order?

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FDA Cautions Consumers About Filling US Prescriptions Abroad

Food and Drug Administration (FDA) issued a warning to health care professionals and consumers that filling their prescriptions abroad may have adverse health consequences due to the confusion with drug brand names that could inadvertently lead consumers to take the wrong medication for their condition. In an investigation, FDA has found that many foreign medications, although marketed under the same or similar-sounding brand names as those in the United States, contain different active ingredients than in the US. Taking a different active ingredient could potentially harm the user.

FDA found 105 US brand names that have foreign counterparts that look or sound so similar that consumers who fill such prescriptions abroad may receive a drug with the wrong active ingredient. For example, in the United Kingdom, Amyben®, a brand name for a drug product containing amiodarone, used to treat abnormal heart rhythms, could be mistaken for Ambien®, a US brand name for a sedative. Using Amyben instead of Ambien could have a serious adverse outcome. For more information on this topic visit www.fda.gov/oc/opacom/reports/confusingnames.html.

Safety Can Not be Sacrificed For Speed

This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency that works closely with United States Pharmacopeia (USP) and FDA in analyzing medication errors, near misses, and potentially hazardous conditions as reported by pharmacists and other practitioners. ISMP then makes appropriate contacts with companies and regulators, gathers expert opinion about prevention measures, then publishes its recommendations. If you would like to report a problem confidentially to these organizations, go to the ISMP Web site (www.ismp.org) for links with USP, ISMP, and FDA. Or call 1-800/23-ERROR to report directly to the USP-ISMP Medication Errors Reporting Program. ISMP address: 1800 Byberry Rd, Huntingdon Valley, PA 19006. Phone: 215/947-7797. E-mail: ismpinfo@ismp.org.

Problem: Typically, pharmacies have developed well-established methods for monitoring the accuracy of the dispensing process. But today, pharmacy work is increasingly stressful and these checks and balances can easily be strained beyond capacity. With an increasing number of prescriptions and a shortage of qualified pharmacists, conditions are ripe for potentially unsafe working conditions – long hours without breaks; multitasking between answering phones, overseeing other pharmacy staff, dispensing prescriptions, and counseling patients; and ever-increasing time spent attending to insurance issues. Inevitably, these conditions can increase the chance for dispensing errors.

One pharmacy knows this all too well after a five-year-old boy died as a result of an order entry and medication compounding error that was not caught by the usual verification process. In this case, imipramine was dispensed in a concentration five times greater than prescribed. Imipramine is a tricyclic antidepressant used to treat adults, but it is also used to treat childhood enuresis. An extemporaneous solution was to be prepared at this pharmacy that specialized in compounded prescriptions since a liquid formulation was not commercially available. A pharmacy technician incorrectly entered the concentration of the prescribed solution into the computer as **50 mg/mL** instead of **50 mg/5 mL**, along with the prescribed directions to give 2 tsp at bedtime. He then proceeded to prepare the solution using the incorrect concentration on the label rather than the concentration indicated on the prescription. When the compound was completed, the technician placed it in a holding area to await a pharmacist's verification. At this time, one of the two pharmacists on duty was at lunch and the high workload of the pharmacy made it difficult for the pharmacist to check the prescription right away. When the child's mother returned to pick up the prescription, the cash register clerk retrieved the prescription from the holding area without telling a pharmacist, and gave it to the mother, unaware that it had not yet been checked. At bedtime, the mother administered 2 tsp of the drug (500 mg instead of the intended 100 mg) to the child. When she went to wake him the next morning, the child was dead. An autopsy confirmed imipramine poisoning.

There are many factors that contributed to this error including inaccurate order entry and issues related to high workload. However, a critical breakdown in safety processes occurred when the cash register clerk took the prescription from the pharmacy holding area (to prevent the mother from waiting any longer for the prescription), thereby circumventing the usual pharmacist verification process.

While this error underscores a growing problem in health care, the problem was clearly evident to this pharmacy owner – even a year before the error occurred. When interviewed for an article that appeared in a national publication, he vented his frustrations about the scant attention paid in our society to pharmacist workload difficulties faced in today's health care environment. On the day of the interview, 49 prescriptions were in the process of being prepared and about a dozen patients were standing in line or wandering around the store waiting for prescriptions. Yet this was a slow day. The owner also said that, while managed care had reduced profits considerably over the past several years, prescription volume had increased 50% (at the time of the error, the pharmacy was dispensing about 10,000 prescriptions per month versus 7,000 per month during the prior year, without an increase in staff) and medication regimens and drug interactions were more complex. To overcome these barriers, the owner added private consultation areas for patient counseling; installed a $175,000 robot that accurately dispenses the 200 most common drugs; and diversified sales to offset full-time pharmacists' salaries. But these efforts could not have prevented this tragic fatal error that circumvented the normal safety processes.

Safe Practice Recommendations: The environment and demands placed on health professionals significantly affect their ability to provide safe health care services. While technology such as robots can help, overstressed professionals cannot consistently perform at the maximum level of safety. Therefore, it is important that the public and health care leadership understand this problem so they can be more open to tradeoffs, such as working

with one patient at a time and incurring longer turnaround times, which are necessary to enhance patient safety. With a shortage of qualified professionals, we need to demand more rapid adoption of computerized prescribing to reduce time spent with prescription transcription. We should identify the biggest distractions that occur in our workplaces and eliminate or reduce the source by batching common interruptions and reorganizing work areas. Staff members need to be properly trained to understand safety procedures that are in place and know the limits of their specific duties. Fail-safe processes to ensure an independent double check before dispensing medications and performing other critical processes are a must. The pharmacy where this error occurred now requires two pharmacists to check every prescription. Unfortunately, this level of vigilance is typical after a patient has been harmed from an error. In other pharmacies, especially where there is only one pharmacist on duty, technicians may be involved in the double-check process.

A few other strategies can be used to prevent similar errors:

- Have one person perform order entry and a different person prepare the prescription, if possible, to add an independent validation of the order entry process.
- Do not prepare prescriptions using only the computer-generated label, as order entry may have been incorrect.
- Ensure that the original prescription, computer-generated label, prepared product, and manufacturer's product(s) remain together throughout the preparation process.
- Verify dispensing accuracy by comparing the original prescription with the labeled patient product and the manufacturer's product(s) used.

NIH Develops Community Drug Alert Bulletin

The National Institute on Drug Abuse, as part of the National Institutes of Health (NIH), has developed a new Community Drug Alert Bulletin that addresses the latest scientific research on the non-medical use of prescription drugs of abuse and addiction.

This bulletin is geared toward parents, teachers, counselors, school nurses, and health professionals who are associated with those at risk from prescription drug abuse for non-medical purposes. It summarizes the growing problem in the US and the trend of non-medical use of prescription drugs. For more information on this bulletin visit www.nida.nih.gov/PrescripAlert/index.html.

Implementation of the Anabolic Steroid Control Act of 2004

According to the December 16, 2005 *Federal Register*, effective January 20, 2005, the Anabolic Steroid Control Act of 2004 amended the Controlled Substances Act (CSA) and replaced the existing definition of "anabolic steroid" with a new definition. This new definition changed the basis for all future administrative scheduling actions relating to the control of the anabolic steroids as Schedule III controlled substances (CS) by eliminating the requirement to prove muscle growth. Also, the Act lists 59 substances as being anabolic steroids; these substances and their salts, esters, and ethers are Schedule III CS. The Act also revised the language of the CSA requiring exclusion of certain over-the-counter products from regulation as CS.

According to the House Report, the purpose of the Act is "to prevent the abuse of steroids by professional athletes. It will also address the widespread use of steroids and steroid precursors by college, high school, and even middle school students."

The changes to the definition include the following:

- Correction of the listing of steroid names resulting from the passage of the Anabolic Steroid Control Act of 1990.
- Replacement of the list of 23 steroids with a list of 59 steroids, including both intrinsically active steroids as well as steroid metabolic precursors.
- Automatic scheduling of the salts, esters, and ethers of Schedule III anabolic steroids without the need to prove that these salts, esters, or ethers promote muscle growth.
- Removal of the automatic scheduling of isomers of steroids listed as Schedule III anabolic steroids.
- Addition of dehydroepiandrosterone to the list of excluded substances.

FDA Unveils New Package Insert Format

On January 18, 2006, FDA unveiled a major revision to the format of prescription drug information, commonly called the package insert, which will give health care professionals clear and concise prescribing information. This new format was developed in order to manage the risks of medication use and reduce medical errors; the new package insert will provide the most up-to-date information in an easy-to-read format. This new format will also make prescription information more accessible for use with electronic prescribing tools and other electronic information resources.

Revised for the first time in more than 25 years, the new format requires that the prescription information for new and recently approved products meet specific graphical requirements and includes the reorganization of critical information so physicians can find the information they need quickly. Some of the more important changes include:

- A new section called *Highlights* to provide immediate access to the most important prescribing information about benefits and risks.
- A table of contents for easy reference to detailed safety and efficacy information.
- The date of initial product approval, making it easier to determine how long a product has been on the market.
- A toll-free number and Internet reporting information for suspected adverse events to encourage more widespread reporting of suspected side effects.

This new format will be integrated into FDA's other e-Health initiatives and standards-settings through a variety of ongoing initiatives at FDA. For more information please visit www.fda.gov/cder/regulatory/physLabel/default.htm.

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Answer: No. Chapter 91 of the Acts of 2005 does not mandate parental consent for teens to obtain EC from a pharmacist or pharmacy. The law does not prevent a teen from involving her parent.

7. **Question:** What should a pharmacist do if a pharmacy customer discloses that the need for EC results from sexual assault?

   Answer: Observe the following best practice suggestion(s).

Provide standard medication screening and offer pharmaceutical counseling consistent with M.G.L.§ 94C § 21A and 247 CMR 9.07. If a patient reports no contraindications, dispense medication per a standing order or, if customer presents a prescription, per the prescription.

Provide appropriate referrals:

- For medical treatment and care, refer the pharmacy customer to a local rape crisis center and/or hospital emergency department.
- For nearest Rape Crisis Center, visit www.mass.gov/dph/fch/sapss/sites.htm.
- For nearest MDPH-designated hospital emergency room that uses MDPH-certified sexual assault nurse examiners to collect forensic evidence, visit www.mass.gov/dph/fch/sane/index.htm

For **confidential** rape crisis counseling, refer pharmacy customer to the state's **confidential** rape crisis hotline:

- For hotline numbers, see: www.mass.gov/dph/fch/sapss/sites.htm.
- For the statewide Spanish Language Helpline, call Llámanos: 1/800-223-5001.

Note: Under Massachusetts law, information transmitted in confidence by and between a victim of sexual assault and a sexual assault counselor including all information received by the sexual assault counselor that arises out of and in the course of such counseling shall not be subject to discovery and shall be inadmissible in any criminal or civil proceeding without the prior written consent of the victim to whom the report, record, working paper or memorandum relates. See M.G.L. c. 233 §20J. The statutory definition for "sexual assault counselor" does not include a pharmacist and the statutory privilege codified in §20J does not apply to pharmacy conversations or records maintained by the pharmacist.

8. **Question:** Are additional MDPH materials available to pharmacists and health care providers?

   Answer: Not at this time.

Some materials are posted on the MDPH and the Board of Registration in Pharmacy Web sites.

MDPH is preparing a pharmacist toolkit that is anticipated to contain other information for participating pharmacists. Check the MDPH and the Board of Registration in Pharmacy Web sites for forthcoming materials.

Standing Order and Physician Practice

9. **Question:** How will a physician know that a particular standing order has been filed with the Board of Registration in Pharmacy and is ready for use?

   Answer: Observe the following best practice suggestion(s).

Best practice(s):

- Send the standing order via certified mail with return receipt requested in order to track delivery and receipt of the order. (The Board will not provide alternative written or oral confirmation of receipt of the standing order on file.)
- On each standardized order transmitted to the Board, include (1) the effective date and (2) the date that the order is transmitted to the Board for filing.

10. **Question:** Does a physician need to verify that a pharmacist has been trained before signing a standing order with that pharmacist?

    Answer: Generally, no but a physician may wish to verify training before signing a standing order.

Under M.G.L. c. 94C §19(A), pharmacists must complete requisite training before dispensing EC per a standing order. Board Policy No. 2006-1 requires that proof of training must be on file (readily retrievable) at the pharmacy.

State law does not require or prohibit a physician from seeking to verify that an individual pharmacist has completed training before signing a standing order.

Nothing prohibits a licensed physician from providing a licensed pharmacy with a standing order that is signed and dated in advance of the date that an individual pharmacist working at such pharmacy completes requisite training, so long as there are adequate personnel and management systems in place at the pharmacy for use of the standing order. A pharmacist commencing employment at a pharmacy that has a standing order on file for use by trained pharmacists may dispense EC pursuant to the standing order provided that such pharmacist has completed requisite training.

11. **Question:** If a physician signs an order authorizing all qualified pharmacists practicing at a pharmacy located at one particular location to dispense per the physician's standing order and one of the pharmacists who works at that pharmacy also works at another pharmacy location that does not have a standing order on file, can the pharmacist "carry" the standing order from location to location so as to "transfer" the physician's standing order to different location(s) that do not have a standing order on file?

    Answer: No.

See Frequently Asked Questions for pharmacists (Question No. 3 on page 5).

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Board Policy No. 2006-1 specifies that a copy of the standing order must be maintained on file (readily retrievable) at each participating pharmacy site.

If the physician's standing order is written to authorize a specific individual pharmacist to dispense per the standing order at any pharmacy where he or she practices, copies of the standing order must be on file at each pharmacy location where such pharmacist practices.

12. **Question:** Will it still be necessary for physicians to write prescriptions for EC now that Plan B may be available at some pharmacies via a standing order?

    Answer: Yes.

Nothing in the new law limits or otherwise changes a physician's authority to write a prescription for Plan B or other prescription medication.

- It is not certain that an individual patient in need of EC will be able to obtain EC medication from a pharmacy without a prescription. Access under the new state law is contingent on a number of factors including, but not limited to: (1) pharmacies "opting in" to dispense under a standing order, and (2) a pharmacist with the requisite qualifications and training being available and ready to serve a pharmacy customer who arrives without a written prescription.
- In cases where a treating physician (or pharmacist acting under a standing order) determines in his or her professional judgment that Plan B is contraindicated but another prescription medication is necessary, a prescription is required.
- In cases where a patient under the physician's care seeks a prescription that can be filled and refilled in the future (eg, while traveling if contraceptive method fails), the best practice for ensuring access to EC is to give the patient a prescription.

13. **Question:** The MDPH model standing order asks the physician to "List Pharmacy or Corporate Entity."
    A. Does this mean that a physician can authorize all pharmacists who work at a particular location (eg, pharmacy ABC located at 123 Washington Street,Town T, MA)?
    B. Can a physician use a standing order to authorize a corporate entity that operates a chain of pharmacies (eg, to the ABC Corporation that owns and operates 20 licensed pharmacies in one or more geographic locations in the Commonwealth)?

Answers to 13A and 13B: Yes.

The scope of the standing order is a matter that is left to the discretion of the physician signing the standing order. A physician may sign a standing order that authorizes qualified pharmacists practicing at a particular pharmacy location or qualified pharmacists who are employed by a particular corporate entity to dispense EC per his or her standing order. Or, a physician may choose to sign a standing order authorizing one particular pharmacist.

14. **Question:** Does a physician who authorizes dispensing per a standing order increase his or her risk of liability?

    Answer: Participating physicians (and participating pharmacists) are advised to consult their legal counsel and/or insurance agent regarding risk management issues and adequacy of professional malpractice insurance.

15. **Question:** Is there increased liability for the physician if his or her standing order is written so as to authorize a participating pharmacist to dispense to pharmacy patients who report having sexual intercourse within the preceding 120-hour period of time if the physician and the pharmacist know that, for maximum effectiveness, EC should be administered as soon as possible and, if possible, within 72 hours of sexual intercourse?

    Answer: Participating physicians (and participating pharmacists) are advised to consult their legal counsel and/or insurance agent regarding risk management issues and liability issues.

16. **Question:** Do new MDPH regulations found at 105 CMR 130.1040 to 130.1043 regarding timely access to EC for rape survivors only apply to emergency departments of hospitals?

    Answer: Yes.

Amendments to the MDPH hospital licensure regulations only apply to emergency departments of hospitals.

17. **Question:** If a woman calls her doctor's office in need of EC, does the new law (Chapter 91 of the Acts of 2005) require her doctor or other licensed professionals in that medical practice to give the caller a prescription or provide her with information on where she can obtain it?

    Answer: No.

The legislature did not change the physician's authority to prescribe Plan B or other prescription medications for EC.

The new statutory and regulatory requirements regarding provision of EC for female rape victims only applies to hospital emergency departments.

Other

18. **Question:** If I obtain EC from a pharmacist pursuant to a standing order, will MassHealth (Medicaid) or private insurance pay for it? Will insurance also pay if I request EC for the future, before I need to take it?

    Answer: The new law does not address matters related to insurance coverage and benefits.

Currently, MassHealth (Medicaid) provides coverage for EC. For questions regarding MassHealth coverage and benefits and applicable co-payment for physician visits and

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for prescription medication, call the MassHealth Customer Service Center: **1-800/841-2900** (TTY: 1-800/497-4648 for people with partial or total hearing loss).

- Questions regarding private insurance products, coverage, and benefits should be addressed to your health insurance plan.

19. **Question:** Who in MDPH handles questions regarding Pharmacy and Emergency Department access to EC?

Contact Information

- Public/Consumers:

  Family Planning Program, Karen Edlund: 617/624-6012

  Sexual Assault Prevention and Survivor Services Program, Marci Diamond: 617/624-5457

- Hospitals:

  Division of Health Care Quality, 617/753-8000

- Pharmacists/Pharmacies:

  Board of Registration in Pharmacy, Chuck Young or J.D. Coffey: 1-800/414-0168 or 617/973-0954

  Drug Control Program, 617/983-6700

- Physicians/Providers:

  Board of Registration in Medicine, Assistant General Counsel Robert Harvey: 617/654-9800

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